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RESEARCH

Atenção à pessoa idosa: fatores que influenciam o desempenho dos profissionais de saúde na atenção básica

Care for the elderly: factors that influence the performance of health professionals in primary care

Cuidado de los ancianos: factores que influyen en el desempeño de los profesionales de la salud en atención primaria

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ABSTRACT

Objective: To analyze the factors that influences the performance of family health teams (FHT) in caring for the elderly in view point of two levels of management (micro and meso). **Method:** Survey that was conducted in João Pessoa-PB, involving 250 health professionals. Data were collected by primary source, using a questionnaire containing questions related to the evaluation of health services in elderly care. **Results:** The components of the micro-management, 22,8% said lack of improvement to work with the elderly, low supply of group activities (26,4%), displacement of the teamwork (18,8%) and somewhat humanized practices (16,4%). Among the components of meso-management were mentioned inadequacy and unavailability of materials and human resources (16,4%/12,4%), inaccessibility (28,4%), low agreement with the principle of integrality (9,6%). **Conclusion:** Increase the capacity of resolution of FHT and enhance the specific functions of micro-management requires technological adaptation/structural units, investment in training, social inclusion the elderly. **Descriptors:** Elder, Primary Health Care, Health Services Evaluation.

RESUMO

Objetivo: analisar os fatores que influenciam o desempenho das equipes de saúde da família (ESF) na atenção a pessoa idosa na perspectiva da micro e mesogestão. **Método:** Estudo tipo inquérito, realizado em João Pessoa - PB, que envolveu 250 profissionais de saúde. Os dados foram coletados por fonte primária, utilizando-se um questionário contendo questões relacionadas à avaliação dos serviços de saúde na atenção ao idoso. **Resultados:** Quanto aos componentes da micro-gestão, 22,8% apontou falta de aperfeiçoamento para o trabalho com o idoso, baixa oferta de atividades grupais (26,4%), desarticulação da equipe (18,8%) e práticas pouco humanizadas (16,4%). Entre os componentes da mesogestão, foram mencionadas inadequação e indisponibilidade de recursos materiais e humanos (16,4%/12,4%), inacessibilidade (28,4%); baixo cumprimento do princípio da integralidade (9,6%). **Conclusão:** Ampliar a capacidade resolutiva das ESF e potencializar as atribuições específicas da micro-gestão requer adequação tecnológica/estrutural das unidades, investimento em capacitação, inclusão social do idoso. **Descritores:** Pessoa idosa, Atenção Primária à Saúde, Avaliação de Serviços de saúde.

RESUMEN

Objetivo: Analizar los factores que influyen en el rendimiento de los equipos de salud familiar (ESF) en el cuidado de los ancianos en vista de la micro y mesogestión. **Método:** Estudio realizado en João Pessoa-PB, con la participación de 250 profesionales. Los datos fueron recogidos por fuentes primarias, mediante un cuestionario que contiene preguntas relacionadas con la evaluación de los servicios de salud en el cuidado de ancianos. **Resultados:** Los componentes de la micro-gestión, el 22,8% dijo que la falta de mejoras para trabajar con el suministro de edad avanzada, escasas las actividades del grupo (26,4%), la desunión del equipo (18,8%) y las prácticas poco humanizado (16,4%). Entre los componentes de mesogestión se mencionaron la insuficiencia y falta de disponibilidad de materiales y recursos humanos (16,4%/12,4%), falta de acceso (28,4%), bajo nivel de cumplimiento con el principio de la integralidad (9,6%). **Conclusión:** Aumentar la capacidad de resolución de la ESF y mejorar las funciones específicas de la micro-gestión requiere una adaptación tecnológica/estructurales, inversión en formación, la inclusión social a los ancianos. **Descriptores:** Ancianos, Atención Primaria de Salud, Evaluación de Servicios de Salud.

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INTRODUCTION

Longevity is certainly an achievement, a breakthrough in the development of society. Improving the quality of life, introducing technological and therapeutic resources decreased mortality from infectious diseases, making the survival of individuals increased significantly. Unlike the speed with which the developed countries have adapted to this demographic change, in Brazil the population became suddenly old, no time for a social reorganization and the health sector to meet the new emerging demands.¹

In the country the number of elderly increased from 3 million in 1960 to 7 million in 1975 and 21 million in 2008 and is estimated to reach 32 million by 2020. In 2025, Brazil will be the sixth country in the world with the largest number elderly individuals, with a representation of 15% of the national population, while one in seven Brazilians will be part of the elderly population contingent.²⁻⁴ Among the Federative Units, the Rio de Janeiro (14,9%) and Rio Grande do Sul (13,5%) remain the states with the highest proportion of elderly people. In 1998, they were, along with Paraíba, the only states where elderly accounted for over 10% of the population.²

These demographic changes are causing a relative increase in the burden of chronic diseases. Both the morphological and functional, biochemical and psychological determine the progressive loss of the individual's ability to adapt to the environment, causing greater vulnerability and higher incidence of pathological processes. Such transformations have demanded readjustment in conducting policies and redesign the forms of assistance in the health care field.¹

In the last decade a number of laws, ordinances and decrees were published with the aim of improving the quality of life for seniors. Social protection legislation introduced advances especially after the enactment of the Elderly Statute (Law 10.741 of October 1, 2003), which guarantees health care for the elderly in full, in all levels of care. On February 22nd, 2006, was consolidated Ordinance 399 thus promoting the health pact which also includes the covenant for life. In this document, the elderly health listed as priority of the three levels of government.⁵⁻⁶ Expected recovery, maintenance and promotion of autonomy and independence of the elderly, directing collective and individual health measures for this purpose, in line with principles and guidelines of the Unified Health System - SUS. To this end, the Family Health Strategy (FHS) is configured as a new paradigm of health promotion, supported mainly by establishing links and creating bonds of commitment and co-responsibility between the health professionals and the population.⁷⁻⁸

It is of primary function of health policies contribute to that more people reach the so-called advanced ages with the best possible health. Active and healthy aging is the major objective of this process. When considering health expanded form becomes necessary, changes in the current context towards producing a more favorable social and cultural environment for the elderly.¹

Thus, the health quality involves multiple aspects and can be defined as the provision of accessible and equitable services, with a great professional level, taking into account available resources, to achieve membership and user satisfaction. With regard to healthcare professionals, it is necessary that they make all their efforts looking for a great professional care thus achieving the highest user satisfaction, also covering the broad spectrum of its powers, namely, the promotion, prevention, assistance and rehabilitation of users.⁹

Health teams, in the exercise of their activities should direct their practices to the attention to the elderly's peculiarities, thus making it more active, changing deeply rooted concepts and use new technologies, innovation and wisdom, in order to achieve fairly and democratic fairness in the distribution of services and facilities to the population group the fastest growing in the country. It is expected that the teams of the FH strategy through various rationales, organize their work processes, grounded by a group of caring practices, resolving and qualified, from the local specificities and needs of individuals.¹⁰⁻¹¹

For this to happen in fact, it is necessary to train professionals for differentiated and multidisciplinary care of the elderly that provides improvements in the quality of life for seniors. There are few studies that proposed to conduct an evaluation of the relationship between professionals and structures of Basic Health Units with the care provided to elderly users and key assumptions and products that result from this relationship.

In this regard, worth mentioning two fundamental and structural points to the good performance of the teams. The first relates to the organization's network of services to the "meso-management." It refers to ways of organizing health systems in order to meet demands for services and health needs. The second relates to the ability to interact with the patient to "micro-management", which is the interaction itself between patient/family health teams and community, which is, in fact, the process of care for people. Requires health care teams prepared, informed and motivated to perform functions and responsibilities consistent with their professional skills.¹²

In this sense this study was to analyze the factors that influence the performance of the professionals of the family health strategy in the implementation of care for the elderly in the context of micro and meso-management.

METHOD

It is a descriptive study, survey type, held in the city of João Pessoa, the state capital of Paraíba. The city has a population of 723.515 inhabitants (IBGE, 2010), and organizes health care on a regional basis in five health districts with 180 Family Health Units (USF) making an 84% coverage.

The current study is derived from the implementation of a multidimensional research entitled "Assistive Technologies for Seniors Served in the Family Health Units", funded by the Ministry of Health of Brazil and coordinated by the Program of Graduate Studies in Nursing at the Federal University of Paraíba - UFPB.

The total study population consisted of professionals from the FHT, medium and higher level, whereas the quantitative USF (180) was provided for population of 724 professionals. It chose a sample of 250 individuals, which ensured maximum error of 5,0% and a 95% confidence level. The selection of the professionals interviewed was for convenience. Data were collected in the first half of 2011 through primary source (interviews with professionals), using a questionnaire containing questions related to the evaluation of health services in care for the elderly. The information gathered was entered and stored in spreadsheet *Microsoft Office Excel 2003* and grouped according to the components of "micro-management" and "meso-management."

Data were analyzed by inferential statistics, which enables the analysis and interpretation of data through parameter estimates of population universe. Therefore, the greatest contribution of statistical inference is to provide a reliable measure for the results. Therefore, statistical tests are used in order to extrapolate the results to the actual distribution in the population for the different variables, which translate into a p-value or at intervals containing the true value of the parameter, confidence intervals - CI. In this study, the parameter in question is the proportion being considered confidence intervals thereof, calculated for a ratio and considering the central limit theorem.

This project was approved by the Lauro Wanderley Hospital Ethics Committee of the Federal University of Paraíba - UFPB, under nº 0598. The confidentiality of the information contained in the questionnaires was guaranteed and written consent was asked to all respondents.

RESULTS AND DISCUSSION

In the first analysis component that adds information about the aspects influencing the performance of health professionals from the perspective of micro-management it is observed that 22,8% (CI: 0,2273; 0,2287) responded that there is a lack of improvement team to work with the elderly. Not always noteworthy is the institutional capacity of health systems in management of human resources is sufficient to meet the staffing problems in the health services, but also to ensure working conditions that favor the contribution of professionals with the efficiency, quality and sectoral productivity.¹³

This deficiency worsens the existing disconnection between professionals, manifested by 18,8% (CI: 0,1874; 0,1886) of respondents. This limitation may hinder some types of care, for example, home visits that require more than one professional in providing service to users, very common in cases of elderly unable to get around to the Family Health Unit (Table 1).

Table 1- Percentage distribution of the components of micro-management that influence the performance of the health teams on health care for the elderly. João Pessoa, 2011

Components		<i>fir</i> (%)	I C
Work process	Team without improvement	22,8	0,2273; 0,2287
	Disarticulation of the team	18,8	0,1874; 0,1886
	Professional disengagement	8,0	0,0797; 0,0803
	Workload of attributions	2,4	0,0239; 0,0241
Health actions	Elder support group	26,8	0,2672; 0,2688
	Routine services and programs	24,4	0,2433; 0,2447
	Communitarian therapy	8,8	0,0877; 0,0883
	Ombudsman Service to support groups	2,8	0,0279; 0,0281
	Physical activities	1,2	0,0119; 0,0120
	Support group	0,4	0,0039; 0,0040
Care promotion	Humanization deficit	16,4	0,1635; 0,1645
	Care automation	3,6	0,0359; 0,0361
	Do not carry out health education	3,2	0,0319; 0,0321
	Focus curativist	2,8	0,0279; 0,0281

The introduction of a team of interdisciplinary work process, and the community as a reference, gives differentiating elements which call paradigmatic changes.¹⁴ Professionals should develop expertise in the field of decision-making, communication and leadership; possess skills aimed at effectiveness and cost-effectiveness of the workforce, appropriate use of available resources (medicines, equipment); be accessible and responsive interaction with patients and the community; maintain the confidentiality of information; ability to assess, organize and decide the most appropriate conduct.¹⁵

On activities performed in the exercise of service to the community (social support network, including family members and caregivers), there is the existence of support groups for elderly and services and routine programs, cited by respectively 26,8% (CI: 0,267231, 0,268769) and 24,4% (CI: 0,243277, 0,244723) of respondents. The existence of specific support group for caregivers of the elderly, was marked by only 0.4% (CI: 0,003984, 0,004016) of professionals, as has highlighted the vulnerability of the elderly, as a necessary "training" especially for people who live daily with this population. Most seniors have chronic diseases, which are inherent in this phase of life and many of them depend on the care of others, be they family or not. This panorama expressed here tends to confront with the proposals of the National Policy of the Ministry of Health of the Elderly, which stimulates the formation and maintenance of the Caregiver Support Groups throughout Brazil.

As for the supervision of these groups, 2,8% (CI: 0,027893, 0,028107) of the population surveyed responded that there is some kind of ombudsman service support groups, that seeks to more closely monitor the activities undertaken with users older, character this very important, but still incipient in the studied scenario.

Regarding the existence of community therapy a small percentage of people reported that provides this service, a figure that shows a large deficit in this area.

The idea of integrated health care, comprises a know-how of professionals, managers and co-responsible for the production of health-users made by people who take care of people. It is crucial to understand that the comprehensive care extrapolates the

hierarchical and regionalized organizational structure to health care, requiring a commitment to multidisciplinary practice.

Changes in professional practices support in the creation of a management system based on critical reflection on the health work and experimentation of otherness with users. In this way, there would be the possibility that, in the daily organization of the relations of the sectoral management and structuring of care, learning and continuous teaching were contemplated, thus generating professionals in the area of skilled health, especially to play their role in the SUS.¹⁵

According to the National Policy of Humanization (2004) when deals with the general guidelines for implementing the same, shall be made necessary, reinforce the concept of extended clinic: commitment to the subject and their collective, encouraging different therapeutic practices and co-responsibility of managers, workers and users in the health production process.¹⁶

Of the total respondents (n = 250), 16.4% (CI: 0,163463, 0,164537), they pointed out that the practices are somewhat humanized. To reach a new understanding of the principles and values guiding humanization, health professionals need to articulate theoretical and technical knowledge of science to the affective, social, cultural and ethical aspects of relationships it establishes through its practice so that humanization does not be restricted to purely technical competence, but mainly to the ability to understand and respect human beings in their different ways of being and existence.¹⁷

Another aspect mentioned by 2,8% (CI: 0,027893, 0,028107) relates to the permanence of curative care. In advance of the ESF would be expected restructuring of services and new intervention practices in health care, to substitute the curative care model. However, it is emphasized that the occurrence of this paradigm shift alone is not enough to ensure a new logic in work organization. It is necessary to "change the subject posed as the protagonists of the new care model"^{18:115}

The primary care professionals should be able to plan, organize, develop and evaluate their actions according to community needs. It is also clear that the quality of health services depends on several factors, among them include the instruments used to define and analyze problems; as well as to evaluate the level of commitment of related professional technical, social and human standards.¹⁹

In the second category, comprising the meso-management components (Table 2), it is evident that 28,4% (CI: 0,2832; 0,2848) of respondents highlighted that affordability has not been guaranteed by the health services. Access involves planned attendance of the care network services as well as coordination between them.²⁰ Understands the interaction between service providers and clients, and indicates the degree of ease or difficulty with which people obtain health services.²¹ Reflects the health system characteristics that act by increasing or decreasing barriers to obtaining health services by the population. It focuses therefore on the degree of fit between the health system features and user in the search process and obtain assistance when needed.²² The health access is closely related to the type of management adopted, identified as unsatisfactory by 6,8% (CI: 0,0678; 0,0683) of respondents. Not always, planning is done properly, either by unavailability of material resources or personnel. However, properly plan does not necessarily imply trace complex plans, often beyond the means and expectations, but actively seeks to know where and how

come the priorities for; with simple measures addressing the health problems of a community.

Table 2: Percentage distribution of meso-management components that influence the performance of the health teams on health care for the elderly. João Pessoa, 2011.

Components		<i>fir</i> (%)	I C
Managerial aspects	Disengagement of the management	6,8	0,0678; 0,0683
	Organization does not favor completeness	9,6	0,0957; 0,0963
	Impaired accessibility	28,4	0,2832; 0,2848
	Fail on reference and counter-reference	7,2	0,0717; 0,0723
Material	Unavailability of medicines	14,0	0,1395; 0,1405
Resources /	Insufficient material resources	16,4	0,1635; 0,1645
Human	Insufficient human resources	12,0	0,1196; 0,1204
Infrastructure	Inadequacy of the physical environment	27,2	0,2712; 0,2728
	Insufficient facilities	27,6	0,2752; 0,2728

Among the respondents, 9,6% (CI: 0,09566, 0,09634) expressed that organization's network services and attention to health does not favor the principle of completeness. Understood as an articulated and continuous set of actions and preventive, curative, individual and collective, at different levels of system complexity, emerges from the ideas of building policies for comprehensive care that expands the horizons where the problems are immersed respecting the specifics of multiple groups.²³⁻²⁴

The composition of main gateway is expected that the teams of the FH strategy, organize their offerings so that only demands that require care in higher technological density services are referenced. The system of reference and counter-reference should move forward in building a network of services structured in completeness. The reference is defined as the act of forwarding a serviced user at a health facility to another for greater technological support. Already counter referral as the act of routing a user to the establishment of origin that said, after resolution of the responsible cause for reference. This structure aims to support and maintain the population's access to services and guarantee respect for their rights and freedom.

This process is essential to have formal administrative mechanisms that record and organize the movement of users and information, and services with different levels of technological density, with greater or lesser reliance to solve the problems.²⁵ In this study, the results show failures reference system, mentioned by 7,2% (CI: 0,071738, 0,072262) of respondents, which shows the managerial difficulty in articulating the various points of the network services.

With regard to material and human resources that the services have to carry out the actions and care population, it stands out that among the factors services and health resources that limit their use by users, the access barrier elected as the most important, in most cases, is the inadequacy and unavailability of material resources, which was signaled by 16,4% (CI: 0,163463, 0,164537) of the professionals interviewed.

The irregularity or unavailability in the supply of basic medicines points to an unsatisfactory action coordination to meet the demand of some facilities, as the provision of medicines depends on a prior management organization. Measures to overcome the deficiency of medicines for primary health care have been recommended, such as

computerization of basic pharmaceutical care information system; access of municipalities to the national system of Ministry of Health price records; implementation of a decentralized system of basic medicines; implementation of effective monitoring systems and basic pharmaceutical care evaluation, training of pharmacists in pharmaceutical care specialization courses; encouraging the establishment of community pharmacies in the cities and production/distribution of rational use of essential medicines norms.²⁶

Attention demand depends on the nature and complexity of the physical resources, human, material, diagnostic and therapeutic involved in service delivery. Especially in elderly care, installed capacity, physical plant can be facilitators or not use. It requires structural devices that facilitate access such as ramps, wheelchairs, handrails, non-slip flooring, etc. Among health professionals, 27,6% (CI: 0,275217, 0,276783) demonstrated that the facilities of Family Health Units are insufficient for the services provided to users, for several reasons: small rooms or evil lit environments unsuitable to care, adaptations that were made for all kinds of services could be provided there, among others. Still, 27,2% (CI: 0,271224, 0,272776) responded that there was an inadequate physical environments of the units for more effective use by users and health professionals, citing, for example, lack of ramps in some environments, preventing or hindering the traffic of elderly and disabled people.

When talking about architectural barriers is understood as poor accessibility or in some cases the lack of it, thus hindering access for people with disabilities, whether permanent or temporary (injured), or even the elderly who, for health reasons, they have problems in their locomotion.

CONCLUSION

With the continuing increase in life expectancy in Brazil, it is of such importance to develop and effectively practice projects for the elderly, seeking substantial and qualitative improvement in health services. It is recommended the implementation, development and maintenance support groups for caregivers, these groups whose main focus the spread of a culture of support for the elderly, so that the attention and care are effective and efficient.

It becomes necessary to develop specific recreational and cultural activities for the elderly, thus seeking to unite the mental health to physical health, as well as the increase of Community therapies and other services, to seek a healthy interaction between the elderly and their family or health professionals and others that it will be related, thus having an active and productive aging.

The implementation of proposals that effectively materialize in greater social inclusion of the elderly, that promotes the humane, efficient care, requires increased and improved training of health professionals so that it can enhance the development of specific functions of micro-management.

In front of the table it is concluded that in the managerial aspects, material and human resources and infrastructure available in the study area need to be improved in view of ensuring a qualified care for the elderly. The organization of work in health facilities

requires managerial strategies to technological adaptation of the units and reference services that enable the standardization of structural resources, expand the response capacity of the FHT teams, promote efficiency in service delivery and ensure the access of the elderly population.

In this sense the "meso-management" is fundamental and structuring the good performance of the teams and relates to the organization's network services and ways of organizing health systems in order to meet demands for services and the health needs. The findings show that overcoming the deficiencies requires conviction and efforts of different actors in the health care system. The manager in charge of planning and efficient distribution of resources, tailored to local realities and needs of the elderly.

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